Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 9, 2008

Dr. Michael Lancaster, Interim CEO
Central Regional Hospital
300 Veazey Road
Butner, NC 27509

RE: CCN: 34-4001

Dear Dr. Michael:

Section 1865 of the Social Security Act and implementing regulations 42 CFR 482, provide that a hospital accredited by the Joint Commission or the American Osteopathic Association will be "deemed" to meet all the Medicare Conditions of Participation with the exception of utilization review. Section 1864 of the Act requires the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency or deficiencies which would, if found to be present, adversely affect the health and safety of patients. If, in the course of such a survey, a hospital is found to have significant deficiencies with respect to compliance with the Conditions of Participation, we are required, following timely notification to the accrediting body, to keep the hospital under Medicare State Agency survey jurisdiction until the hospital is in compliance with all the Conditions of Participation.

We have received a report of the deficiencies found by the North Carolina State Survey Agency during its recent substantial allegation survey of your hospital on September 25, 2008. Based on this report, we find that Central Regional Hospital is not in compliance with all the Conditions of Participation for hospitals. A complete listing (CMS-2567) of all deficiencies found by the North Carolina State Survey Agency is enclosed. These deficiencies have been determined to be of such serious nature as to substantially limit your hospital's capacity to render adequate care and prevent it from being in compliance with all the Conditions of Participation for hospitals.

Central Regional Hospital was found not in compliance with the provisions of:

42 CFR 482.12 Governing Body
42 CFR 482.22 Medical Staff

In accordance with section 1865(b) of the Social Security Act, the North Carolina State Survey Agency will conduct a full survey of your hospital to assess compliance with all the Medicare Conditions of Participation.

After the completion of the Medicare survey, Central Regional Hospital will be asked to submit to the North Carolina State Survey Agency and CMS an acceptable plan of correction for the deficiencies cited that will include acceptable completion dates. ***An acceptable plan of correction must contain the following elements:***

1) ***The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;***
2) ***The procedure for implementing the acceptable plan of correction for the specific deficiency cited;***
3) ***The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;***
4) ***The title of the person responsible for implementing the acceptable plan of correction.***

The requirement that Central Regional Hospital must submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When Central Regional Hospital's plan of correction has been implemented and it has been found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR498.3, this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being forwarded to the North Carolina State Survey Agency, and the Joint Commission. You can pursue your concerns with the Joint Commission on Accreditation of Healthcare Organizations at any time, if you so prefer.

If you have any questions, please contact Janetta Booker at (404) 562-7343.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

Enclosures (CMS-2567)
Cc:JCAHO/AOA
State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on review of the Administrative Policy Manual, Medical Staff Bylaws, Medical / Psychological Staff Bylaws, Credentials Manual and staff interviews, the Governing Body failed to ensure Hospital A. 1. maintained one Medical Staff operating under one set of Medical Staff Bylaws and Rules and 2. maintained an Operational Laboratory for provision of minimal emergency lab services. The findings include: 1. Hospital A located in Granville County, including a Wake County Satellite A location and Granville County Satellite B location failed to have one organized and integrated Medical Staff operating under one set of Medical Staff Bylaws and Rules governing the facility's operations. -Cross refer to 482.22 Condition of Participation: Medical Staff, Condition, Tag A0338. 2. Interview with administrative staff on 9-25-08 at 1630 revealed Hospital A did not have the ability to provide minimal emergency lab services. The interview revealed blood specimens are collected at Hospital A and transported to Hospital B for analysis.	A 043		
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT	A 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 167	Continued From page 1 OR SECLUSION [The use of restraint or seclusion must be–] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on facility policy and procedure review, incident report reviews, medical record review and staff interview, the facility staff failed to ensure safe and appropriate restraint techniques were performed for 1 of 3 restraint records reviewed. (#4) The findings include: Review of hospital policy "Restrictive Interventions - Medical Restraints" effective June, 2008 revealed "Purpose: B. To assure the proper use, documentation, consent, care and safety in the use of medical restraints. ....H Medical restraints must be administered in a secure and safe setting..." Review of hospital policy "Seclusion, Restraint, & Other Interventive Procedures" effective January 17, 2005 revealed "Procedures: E. Restraint. Restraints shall be used only: 1) in accordance with NCI training guidelines;..." Review of Incident Reports revealed an allegation of physical abuse was investigated for pt #4 from 09/12/08 through 09/18/08. Further review revealed the alleged incident occurred on 09/09/08. Review revealed the allegation was substantiated based on review of hospital video, staff documentation, and staff interviews. Further	A 167		

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A 167	Continued From page 2 review revealed staff put their knee on the pt's leg (thigh) while placing the pt's extremity in a restraint. Review of open medical record for pt #4 revealed a 52 year old male admitted on 11/17/07 with dementia and chronic back pain with behavior disorder Review of physician's orders dated 09/09/08 at 0730 revealed a verbal order written by nursing staff for "Pt. placed in therapeutic manual hold x (times) 2 min. (minutes) to remove pt from attempting to harm himself & place him in 4 point restraints to calm down safely Review of Restrictive Intervention Procedures Assessment Flowsheet revealed documentation of the patient was placed in manual and mechanical restraints at 0710. Review of restrictive intervention flowsheet revealed pt was released from restraint at 1020. Interview with patient advocacy staff on 09/24/08 at 1530 revealed during the viewing of the video, it was noted that improper restraint techniques were used to restrain pt #4. Further interview revealed investigation was opened on 09/12/08 and concluded on 09/18/08 with substantiated findings of patient abuse related to the improper restraint technique. Interview with administrative nursing staff on 09/25/08 at 1035 revealed the investigative report is sent to the risk manager and the unit nurse manager after completion. Interview revealed the nurse manager conducts a separate investigation from the pt advocacy office. Further interview revealed after the nurse manager completes his/her investigation, he/she will send recommendations for disciplinary action and re-education to the chief nursing office. Further	A 167		

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A 167	Continued From page 3 Interview revealed the chief nursing office will forward the disciplinary action and any re-education information to the personnel/Human Resource office in Raleigh and notify the Secretary of the Department. Interview revealed there was a nurse and two health care technicians involved in the incident. Further interview revealed disciplinary action was taken for all staff involved. Interview revealed staff were re-educated on the application of restraints with appropriate hold techniques reviewed.	A 167		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on review of the Administrative Policy Manual, Medical Staff Bylaws, Medical / Psychological Staff Bylaws, Credentials Manual and staff interviews, Hospital A located in Granville County, including a Wake County Satellite A location and Granville County Satellite B location failed to have one organized and integrated Medical Staff operating under one set of Medical Staff Bylaws and Rules governing the facility's operations. The findings include. On September 23, 2008 Hospital A administrative staff provided the Bylaws of the Medical Staff of Hospital A for review On September 24, 2008, at 1430 Hospital A administrative staff provided a second set of Medical Staff Bylaws. Based on a review of the document labelled "Medical /	A 338		

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A 338	Continued From page 4 Psychological Staff Bylaws," revealed the bylaws for (name of Satellite A campus). Review of the two Medical Staff Bylaws and Credentials Manuals on September 24, 2008, revealed two distinct and separate sets of Medical Staff Bylaws for implementation as evidenced by the following: a) Medical /Psychological Staff Bylaws : (name) Satellite A location in Wake County, December 2007 b) Bylaws of the Medical Staff Hospital A, June 29, 2008 c) Credentials Manual : (name) Satellite A location in Wake County, December 2007 d) Hospital A Medical Staff Credentials Manual, June 29, 2008 Review of the introduction of Medical /Psychological Staff Bylaws: (name) Satellite A location in Wake County, stated "Recognizing that the Medical / Psychological Staff functions as an agent of (name of Satellite A) to insure quality of medical and psychological care, and that the interest of the patient are met by concerted effort, ...Physicians, Dentists, Optometrists, ...and Nurse Practitioners practicing in (name) Satellite A hereby organize themselves in conformity with the Bylaws hereinafter stated, ...The term 'Hospital' shall be interpreted to mean (name) Satellite A." Review of the introduction of Bylaws of the Medical Staff Hospital A, stated ...The Bylaws define the role of the Medical Staff within Hospital A and delineates Medical Staff responsibilities in the oversight of care, treatments, and services. ...These Bylaws shall provide for Medical Staff	A 338		

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A 338	Continued From page 5 responsibility in evaluating the competency of privileged practitioners and delineating the scope of practice of privileged practitioners and for Medical Staff leadership in (name) Hospital A performance improvement activities. ...The term "Hospital" shall be interpreted to mean (Name) Hospital A." Interview with the Clinical Director on September 24, 2008, at 1245 revealed Hospital A had 2 separate medical staffs. one medical staff at the Wake County Satellite A and one medical staff at Hospital A. The interview revealed there are two sets of Bylaws, one for each Medical Staff. Further interview confirmed one of the differences is the Medical Staff at the Satellite A campus allows psychologist to be members of the Medical Staff and Hospital A's Medical Staff does not allow psychologist to be members of the Medical Staff. Interview with the Interim Hospital A Director, Clinical Director of Hospital A, State Operated Services Staff and Hospital A Administrative staff on September 24, 2008. at 1545 revealed not all the medical staff at Satellite A campus will come to Hospital A but would stay at Satellite A. The interview revealed the President of the Medical Staff for Hospital A was Dr. XXX (name of Physician) and the President for the Medical Staff at Satellite A campus was Dr. ZZZ (name of Physician). The interview revealed when all the patients have been relocated from Satellite A (Wake County) to Hospital A (Granville County) is when the Medical staffs from Hospital A and Satellite A location will be "merged" into one Medical Staff.	A 338		

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A 338	Continued From page 6 Interview with Satellite A executive staff on September 25, 2008, at 0815 revealed the staff member received the Hospital A Bylaws yesterday (9-24-08) to send out to the Medical Staff providing medical services on the Satellite A campus. The interview confirmed there is a difference between Hospital A and Satellite A Medical Staffs. The interview revealed the staff member had been told on Monday that Satellite A campus Medical Staff would continue to operate as the Med / Psy Staff and not be a part of the Hospital A's Medical staff until the relocation of the patients from Satellite A campus to Hospital A was completed Further interview indicated the patients were scheduled to be relocated October 1, 2008. Upon requesting the Medical Staff Bylaws, facility staff provided the following documents: a) Medical /Psychological Staff Bylaws: (name) Satellite A location in Wake County, December 2007 b) Credentials Manual: (name) Satellite A location in Wake County, December 2007 Interview with Dr. ZZZ (name of Physician) on September 25, 2008 at 0825 revealed the Physician was the "President of the (name) Satellite A campus Med / Psy Staff " The physician stated she had served as President for the past two years. Further interview revealed the physician had been informed by superiors to continue with a separate medical staff and operate under the Med / Psy Bylaws on the Satellite location as opposed to the Medical Staff Bylaws of Hospital A. The interview revealed the physician attends medical staff meetings as the President of the Satellite A location Med / Psy Staff	A 338		

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A 338	Continued From page 7 Interview with Dr. XXX (name of physician) on September 25, 2008 at 0940 revealed the physician was the President of the Medical Staff of Hospital A. The interview revealed the physician understood there was "one hospital on paper" but there were two sets of Bylaws and two separate Medical Staffs. The interview revealed if the physician is working at Satellite A location, the physician is to follow the Satellite A's Med / Psy Bylaws, rules and regulations and if the physician is working at Hospital A the physician follows the Hospital A's Medical Staff bylaws, rules and regulations. The interview revealed at Satellite A the psychologist have full voting status as medical staff members which differs from Hospital A. The interview revealed Hospital A medical staff and bylaws were "modeled" after Hospital B. During the interviews September 25, 2008, with the President of the Med / Psy Staff (Satellite A Dr. ZZZ), President of the Medical Staff of Hospital A and Secretary of the Medical Staff, Dr. ZZZ was "summoned" out of the room at 0848. On return to the room Dr. ZZZ stated she had just been notified her position no longer existed. Dr. ZZZ stated "there was no longer a Medical Staff at (name)" Satellite A campus and she was "no longer the President of the Med / Psy Staff" for Satellite A campus. Continued interview with Dr. XXX on September 25, 2008, at 0940 revealed physicians were seeking guidance from the accreditation organization for hospitals regarding compliance with the standards to operate one hospital with two separate Medical Staffs. The interview revealed the charting documentation continued to be used from Satellite A campus and there were differences. The interview revealed there had not	A 338		

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A 338	Continued From page 8 been any specific training/orientation for the physicians for Hospital A regarding fire alarms, layout of the units, and duress alarms. The interview revealed he had received information about the Hospitals from rumor and a local news paper. The interview revealed the medical staff is "out of the loop until the very end." The interview revealed on Monday, September 22, 2008, Dr XXX called a Medical Staff meeting for Thursday, September 25, 2008 at 1100. At 0950, the surveyor and Dr. ZZZ were handed a folded white sheet of paper. Review of the document revealed a "MEMORANDUM" which was electronically transmitted to (name) Hospital A Staff and (name) Satellite A Staff, Subject: "Merger." The memorandum stated: "...effective immediately, the new management structure, policies and procedures, advisory and oversight committees will be in place to manage all of the services provided by (name) Hospital A, regardless of the location. ...The Medical-Psychology Staff and Human Rights Committees of (name) Satellite A are hereby abolished and are replaced by the Medical Staff and Human Rights Committee of (name) Hospital A. We are finalizing the training that has already begun and upon completion of the training implement the (name) Hospital A policies and procedures on the (name) Satellite campus..." Continued interviews revealed, the President of the Med / Psy Staff of Satellite A (Wake County), President of the Medical Staff of Hospital A and / or the Secretary of the Medical Staff was not involved in any discussions or decisions of the immediate "abolishment" of the Med / Psy Staff and the immediate "implementation of the	A 338		

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A 338	Continued From page 9 merged management structure" of the Medical Staff Rules and Bylaws of Hospital A. The three members of the medical staff had no knowledge of the makings of the referenced memorandum. Interview with the Medical Director for Hospital A on September 25, 2008 at 1320 revealed he/she was not aware the Medical Staff at the Wake County Satellite location no longer existed until today when she received an e-mail. The physician indicated she was not involved in any discussions for the immediate abolishment and merger to implement one Medical Staff. In summary, prior to 0950 September 25. 2008 at which time an electronic document was transmitted to hospital staff referencing a "merger," Hospital A and Satellite A operated under two distinct Medical Staff and two distinct sets of bylaws. Nevertheless, facility staff failed to ensure a system was implemented to validate the operational status of the immediately abolished Med / Psy Staff and implementation of the one merged Medical Staff	A 338		
A 341	482.22(a)(2) MEDICAL STAFF CREDENTIALING The medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates This STANDARD is not met as evidenced by: Based on review of the Medical Staff bylaws and staff interviews the Medical Staff of Hospital A failed to examine the credentials for 13 Family Medicine or Internal Medicine physicians scheduled to be on call for night coverage at Satellite A campus.	A 341		

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A 341	Continued From page 10 The findings include: Review of the "Administrative Policy Manual policy number: APM-B.005 effective date: July 21, 2008" under Section 8 "Emergency, temporary and disaster Privileges" revealed "B. Temporary privileges (to fulfill an important patient care, treatment, or service need): Upon the recommendation of the President of the Medical Staff or authorized designee, the Hospital Clinical director or authorized designee may grant temporary privileges to meet an important patient care need." Interview with Dr. ZZZ (President of the Satellite A campus Medical Staff) on 9-25-08 starting at 0825 revealed there was no on call schedule for night time coverage for Satellite A campus starting 10-1-08. The interview revealed she was responsible for the training and supervision of the physicians covering. The interview revealed she was concerned because the Residents that had been covering Satellite A campus on call at night would be pulled to Hospital A effective 10-1-08. The interview revealed she had been told internist would be covering the night time on call for Satellite A campus. The interview revealed these physician would be assigned a 1A status requiring supervision by the psychiatrist. The interview revealed the internist on call will have to be trained in when to call the psychiatrist such as with a child or forensic admission in which the internist would not be qualified to admit. The interview revealed she did not know how she would supervise these physicians since she may not see them Interview with Dr. XXX (President of Hospital A Medical Staff) on 9-25-08 starting at 0940	A 341		

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A 341	Continued From page 11 revealed he was not aware of any meetings planned for the credentialing for the internal or family medicine (medicine) physicians to be taking psychiatric on call for night times for Satellite A campus. Interview with the Medical Director for Hospital A and Satellite A campus on 9-25-08 at 1320 revealed she was responsible for completing an on call schedule and one had been completed for Hospital A and one for Satellite A campus. The interview revealed the credentialing process is routinely initiated by the Credentials Coordinator and she was not sure where in the process she was at for the medicine physicians requesting psychiatric privileges. The interview revealed there were 13 medicine physicians on the on call schedule that had not had an examination of their credentials for psychiatric privileges completed yet. Interview with the Medical Director for Hospital A and Satellite A campus on 9-25-08 at 1410 revealed she had checked with the Credentials Coordinator and the credentialing process of obtaining the information had not been started yet for the 13 medicine physicians. The interview revealed she was not aware until "now" that the application for request for privileges had not been sent to the physicians. The interview revealed three named physicians and one nurse practitioner were on the credentials committee that reviewed the request for privileges, examined for competencies and recommended to the Governing Body for approval. The interview indicated due to the timeframe temporary privileges may have to be granted. Interview with the Credentials Coordinator on	A 341		

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	344001	A. BUILDING _____ B. WING _____	C 09/25/2008

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A 341	Continued From page 12 9-25-08 at 1500 revealed the credentialing process for 13 medicine physicians scheduled for psychiatric on call starting October 1 was not completed. The interview revealed the physicians had not been given the request for privileges yet. The interview revealed the Clinical Director signed off on the approval for temporary privileges when there was not a credentials committee meeting. Interview with the Clinical Director on 9-25-08 at 1625 revealed the credentials coordinator puts together all the information to go to the credentials committee. The interview revealed he would review the information and then the information would go to the President of the Medical Staff. The interview revealed he had been signing off for the approval for appointment for temporary privileges. The interview revealed he was aware that the process defined in the Medical Staff bylaws for credentialing/approval for privileges was not being followed. The interview revealed he was not aware that the physicians taking psychiatric on call at Satellite A campus had not been sent the request for psychiatric privileges required to be granted to be on call.	A 341		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of the hospital's staff nurse job description, medical records reviews, staff and physician interviews the hospital's nursing staff failed to timely follow a physician's order for 1 of 2 closed medical records reviewed (#3)	A 395		

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A 395	Continued From page 13 The findings include: Review of the hospital's "Position Description Form" for a "Nurse B" (staff registered nurse) revealed "I. ...B. Primary Purpose of Position: The Nurse B assumes the responsibility for planning, implementation, and evaluation of nursing care for a designated group of patients. The Nurse B ..as a nurse conducts therapeutic interventions... II. A. Description of Responsibilities and Duties 1. Provides direct nursing care using the nursing process.. 4. Implements therapeutic interventions...6. Plan interventions to address patient needs and ensures that HCTs (health care technicians) follow plan of care . . C. Communication... 4. Documents patient care in medical records...". Closed record review of Patient #3 revealed a 55 year-old male admitted on 09/02/2008 with suicide attempt, alcohol dependence and depression. Review of the initial medical treatment plan initiated by a physician on 09/02/2008 revealed "Problems: malnutrition/underweight". Review of the physician's documentation on the progress notes dated 09/04/2008 at 1015 revealed "Pt (patient) noted by nursing staff c (with) temp (temperature) of 92.4 (degrees) & (and) rechecked of 92 also". Review of the "Flow Sheet" revealed the patient's temperature as follows. 09/04/2008 at 1015 - 92.4 degrees, 1115 - 95.5 degrees, 1330 - 96.7 degrees, 1420- 96.7 degrees, 1425- 95.7 degrees, 1600 - 97.7 degrees. 1730 - 97.7 degrees. 2205 - 95.5 degrees, 2300 - 97 degrees, 09/05/2008 at 0100- 96.2 degrees, 0230- 96 degrees, 0400- 96 3 degrees, 0500 - 96.2 degrees, 0630 - 96.7 degrees. 0820- 96.8 degrees, 0920 - 96.2 degrees, 1025 - 97 degrees,	A 395		

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A 395	Continued From page 14 1125 - 97.3 degrees, 1600 - 97.1 degrees, 2000 - 98.1 degrees. Review of the physician's orders dated 09/04/2008 at 0945 revealed "place pt on bedrest c warming blankets and hat for head". Further review of the physician's orders dated 09/04/2008 at 1100 revealed "Please get knitted cap for pt". Review of the physician's orders dated 09/05/2008 at 1010 revealed "Toboggan hat 24/7 (Volunteer Services will provide)". Review of the record revealed no documentation that a covering was placed on the patient's head as ordered by the physician Interview on 09/25/2008 at 0935 with Patient #3's physician (Staff #16) revealed "I got a call from the nurse that (Patient #3's) temperature was 92.4. I asked them to check it rectally There was poor organization on the unit. They didn't know where to find a rectal thermometer so I called the Geri (geriatric psychiatry) unit and they had one so I went to get it. His temperature was 97.4 rectally so I ordered for him to have a knit cap like a toboggan placed on his head. They told me there was none available. The next day he still didn't have one on so I called volunteer services, they found six" Interview further revealed the patient had no subcutaneous tissue and was oversedated "causing him to have a low temperature". Interview revealed "I had to write the order for the cap three times before it was done". Interview on 09/25/2008 at 1000 with the nursing supervisor shift manager on the adult admissions unit (Staff #17) revealed "I didn't know where to find a cap. I spoke with (Director of Nursing) about it. In the meantime, (named doctor) spoke with volunteer services about it and they were able to find a toboggan". Interview revealed "I	A 395		

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A 395	Continued From page 15 see in the notes where the patient was wrapped in warm blankets". Interview confirmed the nursing notes revealed no documentation that the patient's head was wrapped or covered. Interview confirmed the nursing staff failed to follow the physician's order to cover Patient #3's head .	A 395		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by. Based on policy and procedure review, observation during tours, nursing management staff interviews, the nursing staff failed to ensure an acceptable level of safety and quality for 3 of 3 glucose meter's quality control solutions observed during tour of the patient care units (#1, #2, #3). The findings include: Review of procedure documentation "(Brand Name) Blood Glucose Monitor Operator Training Outline," copyright 2007, provided by nursing management staff on 09-24-2008 at 1130, revealed "Hands-on Training...1 Perform a low and a High control solution test...b Explain the expiration date on bottle vs opened bottle expiration date (90 days). c. Record open date (expiration date) on bottle..." 1. Observation during tour of the E2 Acute Admissions Unit on 09-23-2008 at 1520 revealed 1 glucose meter available for testing the blood glucose level of patients. Observation of glucose meter #1 revealed an opened High and Low	A 724		

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A 724	Continued From page 16 control solution bottles with no open date recorded on the bottle labels. Interview with nursing management staff during tour of the E2 Acute Admissions Unit on 09-23-2008 at 1520 revealed, the glucose meter observed was available to obtain blood glucose levels for patients on the unit. Interview revealed the glucose meter required quality control checks every 24 hours. Interview revealed it is the responsibility of the staff member that opened a new control solution, to record the open date on the quality control solution bottle label. Further interview confirmed nursing staff failed to record the open date on the High and Low quality control solution bottle labels for glucose meter #1. 2. Observation during tour of the D2 Acute Admissions Unit on 09-23-2008 at 1549 revealed 1 glucose meter available for testing the blood glucose level of patients. Observation of glucose meter #2 revealed an opened High and Low control solution bottles with an opened date of 06-11-2008 (opened 104 days prior [14 days expired]) recorded on each control solution bottle label. Interview with nursing staff and nursing management staff during tour of the D2 Acute Admissions Unit on 09-23-2008 at 1549 revealed, the glucose meter observed was available to obtain blood glucose levels for patients on the unit. Interview revealed the glucose meter required quality control checks every 24 hours. Interview revealed the High and Low quality control solutions expire 90 days after being opened. Interview revealed the nursing staff member performing the 24 hours quality control check is to check the labels of the quality control	A 724		

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A 724	Continued From page 17 solutions to confirm the solutions are not expired. Further interview confirmed nursing staff failed to discard the expired High and Low quality control solution bottles upon expiration 14 days prior. Interview confirmed the glucose meter had been used to test patient blood glucose levels in the past 14 days 3. Observation during tour of the F2 Medical Unit on 09-24-2008 at 1045 revealed 1 glucose meter available for testing the blood glucose level of patients. Observation of glucose meter #3 revealed an opened High and Low control solution bottle with no open date recorded on the bottle labels. Interview with nursing management staff during tour of the F2 Medical Unit on 09-24-2008 at 1045 revealed, the glucose meter observed was available to obtain blood glucose levels for patients on the unit Interview revealed the glucose meter required quality control checks every 24 hours. Interview revealed it is the responsibility of the staff member that opened a new control solution, to record the open date on the quality control solution bottle label. Further interview confirmed nursing staff failed to record the open date on the High and Low quality control solution bottle labels for glucose meter #3. NC00049967 NC00049918 NC00049688 NC00050052 NC00050038 NC00050131 NC00049683 NC00049832	A 724		